



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

SURGERY SPECIALTY HOSPITALS OF AMERICA SE
4301 VISTA RD
PASADENA TX 77504-2117

Respondent Name

LIBERTY INSURANCE CORPORATION

Carrier's Austin Representative Box

Box Number 1

MFDR Tracking Number

M4-10-4568-01

MFDR Date Received

June 30, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The information provided by Surgery Specialty Hospitals of America, S.E. was sufficient to support the level of service provided to the injured worker. All disputed procedures performed are well documented. The Carrier did not make payment according to the Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula."

Amount in Dispute: \$3,314.88

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Denied 29827 The code billed does not meet the level/description of the procedure performed/documented... CPT 29827 is defined as follows: Arthroscopy, shoulder, surgical; with rotator cuff repair. The provider completed an Open Rotator Cuff repair... Denied 29824 as Documentation does not support level of service billed... Provider did not state size of excision. April 2004 AAOS Bulletin: Excision of the distal clavicle: This means excision of the entire distal clavicle (approximately 1 cm), not merely shaving off osteophytes at the acromioclavicular joint... Liberty Mutual believes that Surgery Specialty Hospitals of America, S.E has been appropriately reimbursed for services rendered..."

Response Submitted by: Liberty Mutual, 2875 Browns Bridge Road, Gainesville, Georgia 30504

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
March 23, 2010	Outpatient Hospital Services	\$3,314.88	\$2,748.55

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - X936 – CPT OR HCPC IS REQUIRED TO DETERMINE IF SERVICES ARE PAYABLE. (X936)
 - X901 – DOCUMENTATION DOES NOT SUPPORT LEVEL OF SERVICE BILLED. (X901)
 - Z652 – RECOMMENDATION OF PAYMENT HAS BEEN BASED ON A PROCEDURE CODE WHICH BEST DESCRIBES SERVICES RENDERED. (Z652)
 - Z346 – RIGHTS SIDE. (Z346)
 - X263 – THE CODE BILLED DOES NOT MEET THE LEVEL/DESCRIPTION OF THE PROCEDURE PERFORMED/DOCUMENTED. CONSIDERATION WILL BE GIVEN WITH CODING THAT REFLECTS THE DOCUMENTED PROCEDURE. (X263)
 - Z710 – THE CHARGE FOR THIS PROCEDURE EXCEEDS THE FEE SCHEDULE ALLOWANCE. (Z710)
 - B291 – THIS IS A BUNDLED OR NON COVERED PROCEDURE BASED ON MEDICARE GUIDELINES; NO SEPARATE PAYMENT ALLOWED. (B291)
 - U634 – PROCEDURE CODE NOT SEPARATELY PAYABLE UNDER MEDICARE AND OR FEE SCHEDULE GUIDELINES. (U634)

Issues

1. Does the submitted documentation support procedure code 29827?
2. Does the submitted documentation support procedure code 29824?
3. Are the disputed services subject to a contractual agreement between the parties to this dispute?
4. What is the applicable rule for determining reimbursement for the disputed services?
5. What is the recommended payment amount for the services in dispute?
6. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier denied disputed services billed under procedure code 29827 with reason code X901 – “DOCUMENTATION DOES NOT SUPPORT LEVEL OF SERVICE BILLED.” Procedure code 29827 represents an “Arthroscopy, shoulder, surgical; with rotator cuff repair.” The insurance carrier contends that “The provider completed an Open Rotator Cuff repair”. Review of the operative record finds that the provider documented an “open rotator cuff repair (revision)”. Review of the operative report finds that the provider documented “A small incision is made over the anterolateral aspect of right shoulder. Rotator cuff is mobilized laterally and repaired using a suture anchor...” Review of the submitted information finds that the documentation supports performance of an open rotator cuff repair, and not an arthroscopic rotator cuff repair. The submitted documentation does not support the disputed service as billed. The insurance carrier’s denial reason is supported. Reimbursement is not recommended.
2. The insurance carrier denied disputed services billed under procedure code 29824 with reason code X263 – “THE CODE BILLED DOES NOT MEET THE LEVEL/DESCRIPTION OF THE PROCEDURE PERFORMED/DOCUMENTED. CONSIDERATION WILL BE GIVEN WITH CODING THAT REFLECTS THE DOCUMENTED PROCEDURE. (X263).” Procedure code 29824 represents an “Arthroscopy, shoulder, surgical; distal claviclectomy including distal articular surface (Mumford procedure).” The insurance carrier contends that “Provider did not state size of excision. April 2004 AAOS Bulletin: Excision of the distal clavicle: This means excision of the entire distal clavicle (approximately 1 cm), not merely shaving off osteophytes at the acromioclavicular joint”. Review of the operative report finds that the provider documented that “the distal inferior clavicle is impinging upon the musculotendinous junction of the supraspinatus tendon and intraoperative decision is made to proceed with an undersurface partial distal calvicectomy. This is also performed using a full circumference Dyonics shaver.” Per 28 Texas Administrative Code §134.403(d), for coding, billing, reporting, and reimbursement of covered health care, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service. Per Medicare’s Program Integrity Manual §3.3 A and B, “The primary authority for all coverage provisions and subsequent policies is the Social Security Act. The MACs, CERT, Recovery Auditors, and ZPICs shall use Medicare policies in the form of regulations, CMS rulings, national coverage determinations (NCDs), coverage provisions in interpretive Medicare manuals, local coverage determinations (LCDs) and MAC policy articles attached to an LCD or listed in the Medicare Coverage Database to apply the provisions of the Act...an item/service is correctly coded when it meets all the coding guidelines listed in the Current Procedural Terminology-4 (CPT) book, ICD-9, HCPCS and CMS policy or guideline requirements, LCDs, or MAC articles.” The American Academy of Orthopaedic Surgeons is not listed as an authority with regard to Medicare documentation requirements. No information was found to support that Medicare requires the specific amount of material removed from the clavicle to be reported. Review of the submitted medical records finds that the documentation supports the

service as billed. The insurance carrier's denial reason is not supported. The disputed service will therefore be reviewed per applicable Division rules and fee guidelines.

3. Review of the submitted documentation finds no information to support that the disputed services are subject to a contractual agreement between the parties to this dispute.
4. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Although the requestor's position statement asserts that the provider requested separate reimbursement of implantables, review of the original bill submission and the request for reconsideration submission finds no indication to the insurance carrier that separate reimbursement of implantables was requested. Additionally, no manufacturer's invoices for implantables, nor any certification of the amount billed as required under §134.403(g)(1) was found with the submitted documentation. The Division therefore concludes that separate reimbursement of implantables was not requested. The applicable rule for reimbursement is §134.403(f)(1)(A).
5. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published annually in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:
 - Procedure code J3490 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
 - Procedure code J7120 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
 - Procedure code A4649 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
 - Procedure code A4649 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
 - Procedure code C1713 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
 - Procedure code 29826 has a status indicator of T, which denotes a significant procedure subject to multiple procedure discounting. The highest paying status T APC is paid at 100%; all others are paid at 50%. This procedure is paid at 100%. This service is classified under APC 0042, which, per OPPS Addendum A, has a payment rate of \$3,290.60. This amount multiplied by 60% yields an unadjusted labor-related amount of \$1,974.36. This amount multiplied by the annual wage index for this facility of 0.9934 yields an adjusted labor-related amount of \$1,961.33. The non-labor related portion is 40% of the APC rate or \$1,316.24. The sum of the labor and non-labor related amounts is \$3,277.57. If the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of \$2,175, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. Per the OPPS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.3. This ratio multiplied by the billed charge of \$1,449.00 yields a cost of \$434.70. The total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. The APC payment for this service of \$3,277.57 divided by the sum of all APC payments is 76.54%. The sum of all packaged costs is \$7,891.99. The allocated portion of packaged costs is \$6,040.81. This amount added to the service cost yields a total cost of \$6,475.51. The cost of this service exceeds the annual fixed-dollar threshold of \$2,175. The amount by which the cost exceeds 1.75 times the OPPS payment is \$739.77. 50% of this amount is \$369.88. The total APC payment for this service, including outliers and any multiple procedure discount, is \$3,647.45. This amount multiplied by 200% yields a MAR of \$7,294.91.
 - Per Medicare policy, procedure code 29827 is included in, or mutually exclusive to, another code billed on

the same date of service. Separate payment is not recommended.

- Procedure code 29824 has a status indicator of T, which denotes a significant procedure subject to multiple procedure discounting. The highest paying status T APC is paid at 100%; all others are paid at 50%. This procedure is paid at 50%. This service is classified under APC 0041, which, per OPPS Addendum A, has a payment rate of \$2,016.77. This amount multiplied by 60% yields an unadjusted labor-related amount of \$1,210.06. This amount multiplied by the annual wage index for this facility of 0.9934 yields an adjusted labor-related amount of \$1,202.08. The non-labor related portion is 40% of the APC rate or \$806.71. The sum of the labor and non-labor related amounts is \$2,008.78. The cost of this service does not exceed the annual fixed-dollar threshold of \$2,175. The outlier payment amount is \$0. The total APC payment for this service, including outliers and any multiple procedure discount, is \$1,004.39. This amount multiplied by 200% yields a MAR of \$2,008.78.
 - As stated above, procedure code 29827 is not supported. Reimbursement is not recommended.
6. The total recommended payment for the services in dispute is \$9,303.69. This amount less the amount previously paid by the insurance carrier of \$6,555.14 leaves an amount due to the requestor of \$2,748.55.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$2,748.55.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby **ORDERS** the respondent to remit to the requestor the amount of \$2,748.55, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

_____	Grayson Richardson	September 7, 2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.